AZ Medicaid Outpatient Workgroup Meeting

November 9, 2004
11:00 AM to 12:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Sara Harper, AHCCCS

Attendees:

(Based on sign-in sheets)

APIPA	**COCHISE**	**MCP SCHALLER**
Sharon Zamora	*Marcia Goerdt (teleconf)*	*Cathy Jackson-Smith*
AHCCCS	**CMDP**	**PHP**
Howard Beam	*Paula Cook*	*Greg Lucas (teleconfer)*
Susan Carter (EP&P)	*Amanda Worth*	**PIMA**
Cia Fruitman	**DES**	*Marsha Lablanc*
Cynthia Barker	*Pat Fizer*	**PINAL**
Barbara Butler	**DHS/CRS**	*Susan Murphy (teleconfer)*
Brent Ratterree	*Thao Nguyen*	**UFC**
Dick Azzi	**EVERCARE**	*K. Bolton*
John Murray	*Jack Holstrom*	*Jean Warner*
Mark Renkel	**HEALTHCHOICE**	*Kathy Steiner*
Mike Upchurch	*Lori Owens (teleconfer)*	**YAVAPAI**
CARE 1ST	**INC SYSTEM**	*Becky Ducharme*
Anna Castaneda	*Joelle Di Tommaso (telecon)*	*Jean Willis*
Michael Boisseru		

1. Welcome (Lori Petre)

Item one on the agenda is the timeline. Firm dates are being updated for development and system integration testing. We want to remind everyone to send issues to the Outpatient workgroup email address. They are documented, tracked and serve as an important tool. We will go through the final AHCCCS system proposals next.

2. System Requirements/System Proposal Status (Mike Upchurch)

The System Proposals are finalized. What we will do is go through claims first and then encounters. Since there haven't been any changes to the Reference and Provider document for a while, we won't review it again, but if you have questions we will discuss them after encounters.

Mark Renkel-We will start on page seven. What is new to the claims system proposal from the last draft reviewed, is the surgical procedures with a Payment status indicator or 's' or 't' will not be discounted. Outpatient claims with late charges will not be accepted. The original claim will need to be voided and resubmitted. The duplicate check will be bypassed if the condition code G0, distinct medical visit, is billed on one of the claims. In addition, any lines billed with modifiers 25, 27, 59, 76 or 77 will also be exempt for duplicate check at the line level. A separate SSR will be created for HIPAA related changes, which are 999 UB-92 lines, 4 digit revenue codes, and procedure code format. The only other addition is the critical edits, modifiers and other relationships on page 8.

Lori-Again, we'll review outstanding issues at the end.

Howard Beam-Encounter changes will mirror the claim changes with the exception that we will pend and not deny. We'll develop a message that says to go back and resubmit the entire claim for late charges. We'll use the same bypass logic in the duplicate checks and for various modifiers. The duplicate checking that we are doing will be streamlined. We will be deactivating specific duplicate edits and consolidating error codes where appropriate. Again, the 999 lines and four digit revenue codes are a separate SSR and not part of this project. This is all outlined in the system proposal.

HP Question-If we have two separate ER visits, will we have to have modifiers to distinguish between the two?

Howard-Correct, the second will pend if no modifier.

Mike Upchurch-Are there any questions that you have concerning these documents? We do have a few outstanding items that we are working on. Last week we addressed what we could so that we could move forward with our reference tables and coding to meet the deadline. We have identified the edits to put in place and we are looking at what surgical codes will be paid at 100% and 50%. We are also looking at modifiers. As soon as these last few items are ironed out, we'll let you know.

Lori-Any changes to the documents will be reflected in the document and through the change control process, then shared with this workgroup.

Mike Upchurch-We need to test and have all this in place by July 1st.

Question HP-The surgery and ER is not the same bundling process as Medicare?

Sara Harper-Yes, but not for laboratory.

Question HP-Will any claim with 999 lines be rejected?

Mike Upchurch-We will continue to process the way we currently do, to pend.

Health Plan-It gets denied.

Mike Upchurch-Encounters or claims?

Health Plan-Encounters.

Mike Upchurch-We'll have to check this and get back to the group.

ACTION ITEM: Mike to check on how we currently process claims with more than 999 lines. Do we pend or deny?

3. Discussion of Flow Chart (Cia Fruitman)

Lori-We previously walked through the flowcharts, but Cia has made some updates to it. Cia will now review it.

Cia-The chart is now more in line with the pricing logic that is in the documents. The edit process will look similar to the 1500's. We added correct coding edits, which is #6 on the decision tree. When we implement, we will put the tables for edit and pricing on the ftp server and you will be able to retrieve them. For CCI the edit on UB's is so that if they bill one code that code will be inclusive, modifiers will override. Claim will deny and it is similar to 1500's. The actual table numbers that we will be using is on the decision tree. On the pricing page there is a major change, which is the multiple surgery discount.

After it applies the adjustment, it will determine if discounted. Otherwise it is the same before. Maternity nursery same day will pay the lesser of the OP fee schedule amount or the tier. This is the Pays Lesser of logic. Any questions?

HP Question-Will bundling edits follow CCI and Medicare?

Cia Fruitman-For ER and surgical. There are two exceptions. They are the transplant revenue codes. Question HP-The reference tables are important to us, but there are other numbers on the document that are not meaningful to us and is hard for us to understand. Can we get a list of the number of tables that we care about?

Cia-You can look at those online.

John Murray-It will be reference table 03 on page 58 of the proposal. How many of you have access to online?

HP-What do you mean?

Lori-Some health plans have limited PMMIS access and would view the actual screens. For purposes of clarification, we will update the document with a one page summary that cross-references screens to table layouts.

ACTION ITEM: John to complete a crosswalk.

HP Question-For multiple surgery discounting, will you pay them in sequence that the surgical codes are billed?

Cia- No. We are still working on this piece of logic. We will do a change request to the proposal once we figure it out.

HP Question Can we get the latest draft of the fee schedule?

Cia-The latest version was sent to the hospital for impact testing. We will have something that you can test. They may not be the final rates, but we'll make them available as soon as possible.

HP Question-I heard a discussion about tables online. Where are they?

Brent Ratterree-Staff that has access is getting it from the mainframe. We need to identify who has access to the mainframe within health plans.

4. Review of Action Items (Lori Petre)

Units and limits applied to UB's are still being defined. Sara is putting together a laundry list of and we'll get that sent out. Edits and modifiers are still outstanding. We will share tables as they are added. We're fairly close, but we'll let you know. The surgical issue we already talked about. The question regarding adjustments, Cia says that we are talking about recycling the claim as an original, but we haven't figured that out yet. On the pharmacy markup, Sara says that we are still looking at the initial analysis. We have to see volume and ones that are not on the fee schedule.

5. Other (Lori Petre)

Although system proposals are final, please get your comments and questions to us. All changes will go through our management process. Development started last week and we are currently targeting the end of the year to complete coding, so that we have an internal testing window. We have told the hospitals that we will be ready for pilot testing February 1st. We will try to do as much parallel testing as possible. On February 1st, the health plans can pilot also. User acceptance testing is to start March 1st, and trading partner testing is March 1st through June. Testing is required for every hospital. During the

same window (around 5/1) will be when the 999 lines will be available for testing. We still plan to get the tables verified and finalized by the end of May.

6. Closing Remarks and Next Meeting (Sara Harper)

Sara-Starting this week, we will work with a group of hospital staff that is part of a core work group. This includes technical system staff, as they too want to get a comfortable feeling on what we are doing to our system and that what we are sharing with you is going to happen to our encounter system so that they understand that all of the entities are going to be adjusting their systems to be prepared on July 1st. As time goes by, most parties are going to be similar or identical to the fee schedule that AHCCCS proposes at that time until everyone gets comfortable with it. There will be different contracts that you have carved out for certain service areas, but our fee schedule that we are proposing is still the fee for service fee schedule that you are adapting the methodology. Hospitals are concerned that since we have contractors across the state with their own systems, and then AHCCCS has its own system, and that all parties going to a fee schedule can process multiple claims and come up with the same payment amount using the AHCCCS fee schedule whether billing AHCCCS or the contractor assuming that all things are equal. We are going to work with them and show them our system proposals and answer their questions like we are doing for you. For hospitals that have shown interest in becoming our partners for testing, this will put them in the loop for that. One item in the back of the packet is titled "Draft for Discussion." We want to track contractor progress. The director has disgression by contractor to allow by month an opportunity to continue paying the cost to charge ratio method if they are not ready July 1st. It is a month-by-month approval. AHCCCS would like to have everyone ready on July 1st. We have already delayed this from January 2005 until July 2005 and would like everyone on board. We were asked to prepare a schedule using a tracking mechanism that would keep track of each individual contractor. This is in your packet. Each health plan is to fill out a form to tell us what your proposed begin and end date will be and we will keep track of it for each of you. These are the main milestones; Requirements, Design, System Development, Acceptance Testing, Trading Partner Testing with Hospitals and Implementation of Changes. It is proposed to be updated bi-monthly by email status and we will use it for contingency planning as needed. Tom wants to see our movement forward. If there are issues with timelines, let us know. We want to help you. The dates on the form should be 2005.

Lori-The other handout is a high level layout of our testing approach. For the next meeting we will have a detailed test plan that we will send out prior to the next meeting. The next meeting is December 7th, and beyond that I haven't scheduled any meetings. I will schedule a January meeting and then after that we can assess our meeting schedule.

ACTION ITEM-Lori to send out test plan.

ACTION ITEM-Lori to schedule January meeting.

Sara-Possibly in February and May we would have targeted times to meet with each individual contractor and go over your schedule, requirements, and design documents one on one so that we know where you are. Are there any questions?